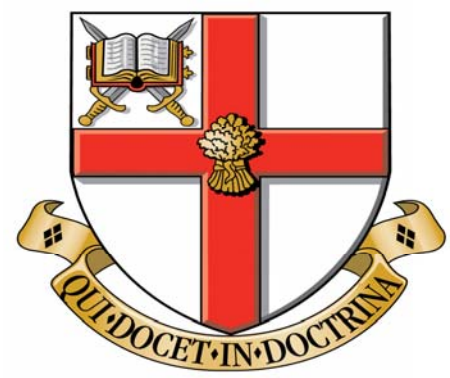

University of Chester

SAFEGUARDING CHILDREN IN THE NATIONAL HEALTH SERVICE: A STUDY OF GOVERNMENT POLICY DEVELOPMENT AND ITS IMPLEMENTATION BY STRATEGIC HEALTH MANAGERS IN THE NORTH WEST

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ABSTRACT

There are approximately 1.6 million children and young people under the age of 18 living in the North West of England (NHS NW, June 2011). Each of them is entitled under international and national laws to protection from harm.

This research sets out the context in which England's national policy for safeguarding children is developed and how this is implemented in National Health Services (NHS) across the North West.

The context setting of legislation is important because of the cultural backdrop this sets for strategic health managers. These managers are responsible for ensuring local health services satisfy national and local requirements, and are keeping children safe.

The timing of this research is particularly relevant because of the current reforms the NHS is undergoing, which means that from April 2013 new commissioning arrangements for health services will be in place.

A conceptual framework sets out an ecological framework in which policy makers and these managers operate, highlighting key factors which influence decisions.

Although much academic and action research has been undertaken in this field, very little has been done in respect of this strategic group of health service managers. This original research explores, through a quantative approach, some of the key influences on these managers.

The research findings identify the powerful effect of public opinion on the managers, and that the influence of policy and prioritisation is strongest when this is applied locally. This is important when one considers the Government's commitment to local organisations taking greater responsibility for identifying local priorities rather than being set centrally.

Finally, recommendations for utilising the learning from the research are proposed for the researcher's organisation, the Strategic Health Authority (SHA) for the North West.

DECLARATION

This work is original and has not been submitted previously for any academic purpose. All secondary sources are acknowledged.

Signed:

Date: October 2012

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CHAPTER 1. INTRODUCTION

1.1 Background to the Research

The United Nations Convention on the Rights of the Child (Article 6) states that *'every child has the right to life. Parties shall ensure to the maximum extent possible the survival and development of the child'* (UNICEF, 1989)[1].

At its heart therefore safeguarding is about protecting children from all forms of abuse and harm. To hold public bodies responsible for this, United Kingdom governments have laid laws and regulations that attempt to bridge the gap between those policy objectives and day to day practice in every public service. There has been particular emphasis on health, social care, education and policing (Laming, 2009).

The focus of this research is the development of safeguarding children policy at a national level and how this is translated by managers and practitioners at a local level through health organisations, and in particular Primary Care Trusts (PCTs).

Created in 1999, PCTs have statutory responsibilities (Her Majesty's Government, 2006) to work with local partners, in particular the local authority, to commission health services for the local population. The role has changed over time to have a greater public health aspect, and more recently the provider side of PCTs have been separated from the commissioning side.

This research was written at a time when PCTs were preparing to handover their responsibilities to Clinical Commissioning Groups and the NHS Commissioning Board as part of the Coalition Government's reforms of the the NHS (Her Majesty's Government, 2012). Details of the impact on safeguarding were not confirmed by the time the research was completed (August 2012).

1.2 Research Question

The principal research question is how effectively national policy and strategy for safeguarding children is translated by management into local practice. There is a brief examination of generic policy development to set the context that may

[1] A child is defined as a person under 18 years of age (Her Majesty's Government, 2004).

then influence how policy is converted to practice. This is followed by policy which is specific to safeguarding.

The theoretical understanding of the problem is tested with senior safeguarding health managers in the North West of England to identify the factors which influence their priorities and the way they oversee safeguarding improvement.

1.3 Research Aims

The research aims are derived from the broader research question, and are focussed on the methodologies commonly used in this context to improve services:

- through performance management methodologies;
- continuous improvement methods used by Health organisations to learn from practice/serious incidents of Safeguarding (Joint Reviews and peer reviews);
- and a systems methodology approach.

1.4 Justification for the Research

This research problem has been selected for three main reasons. Firstly, as this paper will show, there has been a significant degree of public and political interest in the topic area, often prompted by high profile cases of abuse. The question of the effectiveness of policy in response to specific events, as opposed to being developed on the evidence base away from the heat of publicity, is examined.

Secondly, there is a growing body of evidence indicating the long term harm caused to children who have suffered abuse, manifested in psychological and physical ways (Nanni et al, 2012). If organisations can reduce child maltreatment, society benefits as well as the individual.

Thirdly, there is a topical importance for the health service because it is undergoing one of its most profound structural changes. This has generated concerns that the changes may weaken health organisations' safeguarding systems (RCPCH, 2012; NHS Confederation, 2011). The Coalition

Government's own independent safeguarding review formally raised concerns about this very issue as well (Munro, 2011).

1.5 Methodology

The researcher reviewed the prevailing research on how government policy is developed. This was then explored in more detail in the specific context of safeguarding children. The review on research then examined three management models for converting policy into practice, on the basis these tend to be the most common in this field.

The principal exploratory goal for the research was to identify some of the main influences on strategic health safeguarding managers when they develop local priorities based on national guidance, and to what extent this affects what they do. The research element therefore involved a census of all 28 senior managers in the North West of England responsible at a strategic level for safeguarding children in health services.

Chapter 3 gives the methodology in more detail and explains why a census was used rather than other research methods.

1.6 Outline of the MBA Dissertation

Chapter 1: Introduction - sets out the justification for the research and the key aim and objectives. A short description of the adopted methodology is given.

Chapter 2: Literature Review – examines and summarises the literature review on how Government policy is developed in general terms, and specifically on safeguarding. Some reference is made to international studies in similar contexts. The managerial role in interpretation of goals into service delivery is then studied, with a focus on three common models.

Chapter 3: Methodology - describes the methods used to explore both the research question and the aims. The approach adopted and the design of the research instrument are explained, as well as ethical considerations.

Chapter 4: Findings – provides an analysis of the findings from the census of senior health managers responsible for safeguarding across the North West.

Chapter 5: Conclusion – the methodology used is critically reviewed, followed by a critical analysis of the research objectives and research question. The chapter ends with an examination of the implications for the research question.

Chapter 6: Recommendations – draws on the findings and conclusion of the research and offers recommendations to NHS North West to improve effectiveness on safeguarding in the context of the research question.

1.7 Definitions

The legal definition of a child is a person up to their 18th birthday (Her Majesty's Government, 2004). Additionally, children who were under the care of the local authority and/or have a learning disability, will receive such protection as if they were a child up to their 21st birthday (Her Majesty's Government, 1989).

For the purposes of this paper, the term includes young people under that age, to avoid having to repeat the standard reference to '*children and young people'*.

Safeguarding in this paper refers to safeguarding children, unless otherwise made explicit that it also includes vulnerable adults. The national government's definition of safeguarding includes the protection of children from maltreatment, preventing impairment, ensuring the provision of safe and effective care, and to enable children to have the best life chances (Her Majesty's Government, 2010).

References to health services refers to National Health Services (NHS), including those that now have Foundation Trust status. Private health care providers are not included in this definition unless otherwise made explicit.

1.8 Summary

This introductory chapter has described the research problem and question. A justification for the research is given, followed by a short description of the methodology and an outline of the report. On these foundations the dissertation can proceed with a detailed description of the research.

CHAPTER 2. LITERATURE REVIEW

2.1 Introduction

This Chapter starts with the theoretical framework used since the 1980s by successive governments which has informed national policy developments with regards to the welfare of children – the ecological model.

There is then an exploration of the research and evidence of how Government policy is developed generally, and then specifically for safeguarding, and how effectively managers implement these policies locally.

This is followed by looking at three models for developing and delivering optimum safeguarding services. The first model looks at a practice and regulatory approach, which consists of the performance management model. The second is the research on learning from the past, through a continuous improvement model. The third is on the system methodology approach, which is currently supported by Government and is informing changes to safeguarding regulations and guidance.

Drawing on the literature review's research, a conceptual framework is then presented.

2.2 Ecological Theory and Children's Welfare

More than thirty years ago the seminal work of developmental psychologist Urie Bronfenbrenner (1979) argued the importance of an ecological conceptual framework. In this viewpoint the individual and the environment (society) *'must be viewed as interdependent and analyzed in systems terms'*. Figure 1 below illustrates this.

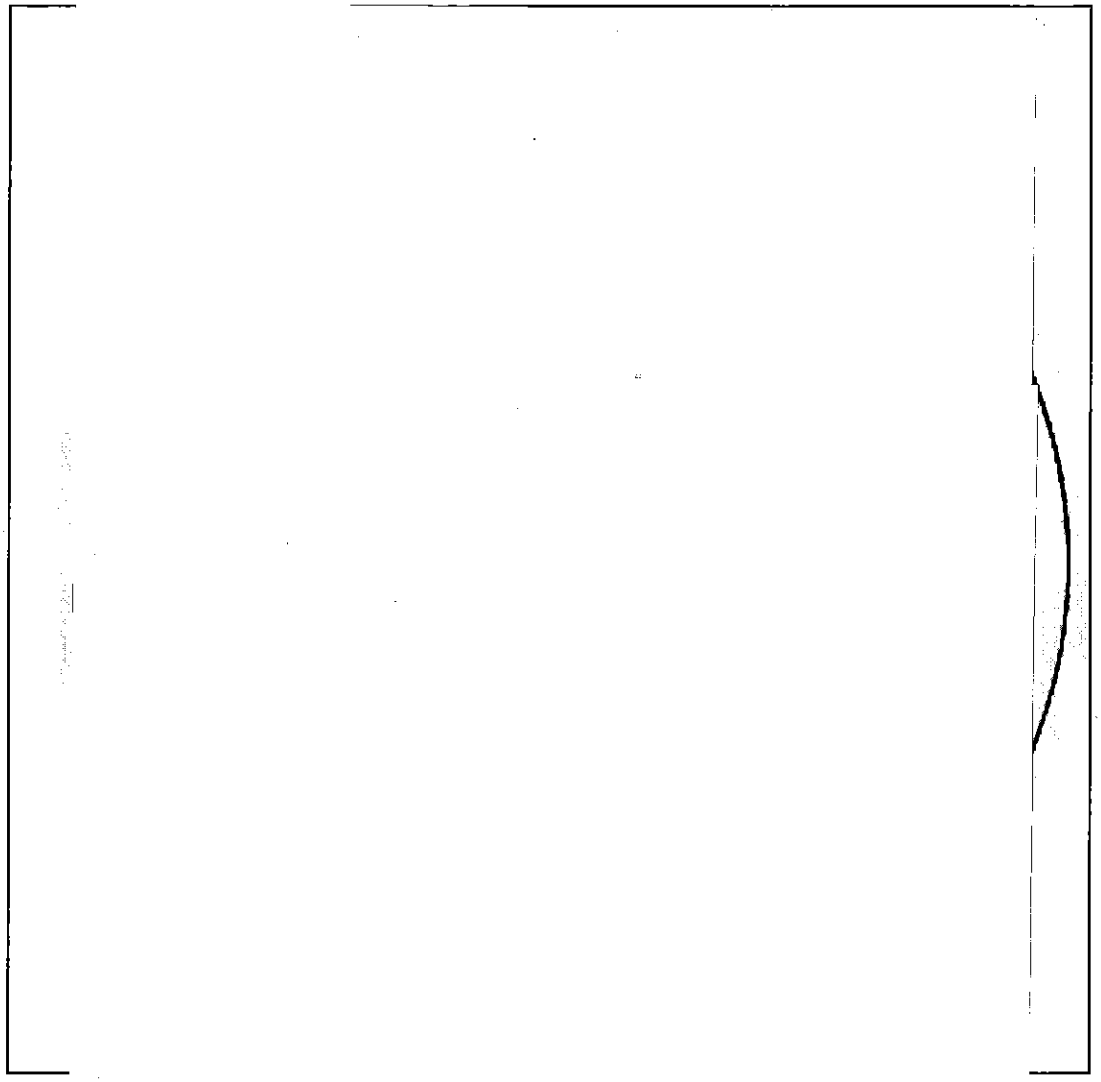

Figure 1 Bronfenbrenner's Ecological Theory[2]

Ruth Gilbert et al (2009) advocated the ecological model because it recognises the inter-dependencies of community, culture, the individual and the family and thus the risks and protections they can give to children's safeguarding. This has led to a greater demand from policy makers that services should be more child-focussed and outcomes focussed (Gilbert, N., et al, 2011).

Thus in the late 1980s the then Labour Government shifted the approach to child safety from what had largely been child protection, to a wider definition of safeguarding. Parton (2011) highlights this change as one where the *"the state developed a much broader focus of concern about what caused harm to*

[2] Retrieved from the World Wide Web in July 2012 at: h p://faculty.weber.edu/tlday/1500/systems.jpg

children and what the role of professionals and official agencies should be in relation to this".

The changes in emphasis in the United Kingdom were also taking place in other industrialised countries, including Australia, Norway and the United States of America. Drawing on research and evidence based practice, the shift is towards early intervention (both in terms of age and need), seeing the child's needs in their totality, and that social work is one of several services which has responsibility to keep children safe (Munro, E.R. and Manful, E., 2012).

In 2000, Victoria Climbie's prolonged abuse and ultimate death at the hands of her relatives, despite the involvement of many social work and health staff, prompted a radical rethink of the way in which agencies protect children. The subsequent Laming review concluded agencies were not working effectively together (Laming 2009).

The Labour Government brought in new requirements for local authorities to work more closely and formally with partner agencies through Children's Trusts. Organisations were advised to adopt a more preventative approach than a purely reactive child protection one. The contention for these changes was that there was a compelling theoretical and conceptual basis for prevention based on *populations* rather than just on *individuals* – seeing systems and communities as part of the problem and solution, rather than just individual professional failures to act properly (Barlow and Calam, 2011). Both the Labour Government, and subsequent Coalition Government, have consequently made commitments to early support and intervention for infants through strengthening, and latterly increasing, the Health Visiting service (Ly, 2009).

The Labour Government was determined that expectations of joint working at local levels should be reflected in what government departments were doing. Departments, other than the main two for social work and health, were therefore also given responsibility for safeguarding children. In 2008 the then Government published a cross-government strategy which set out Public Service Agreement 13 to monitor and evaluate all departmental policies to keep children safe (Her Majesty's Government, 2008). This was reinforced by the establishment of a cross-departmental National Safeguarding Delivery Unit in July 2009, but

disbanded later by the Coalition Government in 2010. Joint Reviews were established between the two principal Departments, for Health and for Education, which would carry out a cycle of independent reviews of local areas' safeguarding practice, performance and leadership.

By 2010, research showed that at strategic and operational tiers, professionals from across key agencies embraced the notion that '*safeguarding children is a shared responsibility, rather than one confined to Children's Social Care'* (France et al, 2010). Horwath and Morrison maintain that there is now a recognition internationally that collaboration between agencies is fundamental to any successful strategy to meet the needs of vulnerable children and families (Horwath and Morrison, 2011).

At a local level this model has been developed into three tiers of collaboration (Miller and McNicholl, 2003). At the minimum level there is coordination consisting of joint working, but no consequences for the agencies if any of them do not comply with any agreements. The middle tier is a coalition where there are some joint structures and formalised joint ways of working. At the highest level there is integration, where in effect a new organisation or agency is created with a single identity (Roaf, 2002).

2.3 The development of government policy

Legislation to define, and make illegal, abuse against children goes as far back as 1933 with The Children and Young Persons Act (Her Majesty's Government, 1933). This legislation identified offences that constitute child abuse, what practitioners and child protection agencies still classify as Schedule One Offences.

Since the mid 1980s there have been at least 19 major Acts, Guidances, or Parliamentary approved independent reviews of child safeguarding (Wilson, 2008). Each of which have usually placed additional responsibilities on local authorities, health services and the police in particular.

Lachman and Bernard (2006) argue that the political demand for regulatory changes stems largely from the public exposure of extreme examples of individual child abuse – cases such as Jasmine Beckford in 1984, Victoria

Climbie in 2000, and most recently Baby Peter in 2008. They contend that the United Kingdom is no different to other countries with *"perceived failures resulting in the strengthening of child protection laws, increased inspection and an attempt to close the cracks through which a child can fall"*.

There is significant debate as to how government policy, in general and not specifically just this topic, is developed. Bismarck (undated) is famously quoted as warning that '*People who love the law or good sausage should never watch either being made'*.

The key questions are to what extent does the evidence base inform policy development, to what extent do media campaigns, interest groups and of course the views of legislators and policy makers themselves? Consensus would suggest that all these interests and influences help to shape policy making and implementation, as well as *'the pragmatics and contingencies of everyday political life'* (Davies, 2004). The pragmatic element is stressed by the previous Government's own Prime Minister's Strategy Unit's guide on policy development to the Cabinet (2004). Davies' model of the inter-relationship of these domains is set out in Figure 2 below.

Figure 2 - P. Davies' model of policy making, 2004

Gray contends that time is also a significant factor in the development of policy, with the influence of evidence gaining greater importance the further time elapses (Gray, 1977). The importance of timing is described as the *'policy window',* which is particularly relevant in the context of responding to safeguarding 'scandals' (Kingdon, 2002).

Another key influence is public perception, often generated by the media, as we have seen in cases such as Climbie and Baby Peter where "*the intense and rancorous social and media reaction clearly engendered a sense of very high anxiety amongst government officials*" (Garrett, 2009).

The inter-relationships of stakeholders in the public sector means that how strategy is designed, and then how it is implemented, are inherently more challenging and complex than in the business sectors (Buller and Timpson, 1986; and Bryson, 1995). It cannot be assumed that public services share similar cultures or are homogenous in the way they work - thus effective cross-agency relationships have to be clearly expressed and defined (Tomison and Stanley, 2001).

In the field of safeguarding children, the importance of local leaders and managers being able to consistently translate national policies, legislation and guidance into effective practice was described as one of the biggest challenges facing services (Lord Laming, 2009).

Jack and Gill (1997) describe a gap between the development of central government policy and day-to-day practice of safeguarding. This theory contends that governments are often led by the latest high profile media-led cases, which caricatures staff as wedded to out of date practices and thus should be sacked. The influence of Governments, and the values of professionals and individuals, also means that definitions of what safeguarding is, and how to improve it, varies (Parton, 2006).

In the following section we examine three common models of how this has been done – there are a number of variations in each model but because of the word limitations for this work the main features have been summarised.

2.4 Models for developing and delivering optimum safeguarding services

This section looks at three of the most common models used in England in the field of safeguarding. As with the operational nursing model, with its five key functions of Assessment, Nursing diagnosis, Planning, Implementation, and Evaluation, these are not separate or sequential activities, but constantly overlap and inter-relate (Fedoruk, 2012).

2.4.1 A Performance Management model

In the wake of the death of Baby Peter in 2008, a guide for councillors and senior managers suggested that "*it is not possible to protect every child from harm or to be certain that things will never go wrong"* (CfPS and iDea, 2009).

This advice would appear to fly in the face of public and political expectations – Power (2007) suggested that "*governments increasingly promote a view that all risk is foreseeable and manageable*". Indeed, the same suggestion by the accountable Director of Children's Services, Sharon Shoesmith, in the review of Baby P's death, led to a national newspaper campaign, successfully, for her dismissal (The Sun, 2008).

The view of many policy makers that all children can be kept safe from harm through regulation is a theme highlighted earlier - successive governments have introduced a significant number of legislation and guidance to greater regulate the process and activities of frontline child protection services and practice. The intention was to remove, or significantly reduce, the chance of harm happening to children by performance managing the work of key staff in health and social work, and using performance indicators as a means to measure effectiveness.

In the field of healthcare the importance of reducing variation in the way services are delivered is stressed by Berwick (1991), who describes variation in performance as *'a thief. It robs processes, products and services of the qualities that they are intended to have'.*

In 2009, the Centre for Excellence in Outcomes described the importance of skilled supervision and reflective practice in managing safeguarding professionals' performance (C4EO, 2009). Fedoruk replicates this for nurses (the professional background for all this research's respondents), as part of their training and ethos (Fedoruk, 2012).

At the time of writing this would have echoed the Government's push on more effective performance management of front-line safeguarding professionals.

Alongside this approach, and to challenge claims that there were not enough staff involved in safeguarding, Fauth found that resources for child protection, and staff capacity, were not the key factors behind why cases of abuse are not identified or dealt with effectively (Fauth, 2010). By implication the fault lies in how professionals act, rather than their numbers.

The Labour Government's increased focus on measuring processes and giving local agencies greater guidance on structures was seen by Das and Teng (1998) as the means by which desirable member (employee) behaviour could be achieved. This model is described as single-loop learning, where performance management is '*a thermostat that learns when it is too hot or too cold and turns the heat on or off*' (Argyris and Schon, 1978).

Thus government sets out what is expected through policy and guidance, measures this through performance targets and inspections, and demands changes of local agencies if the 'temperature' is either too hot or too cold.

One of the key methods for this was the establishment of Serious Case Reviews (SCR), which are established following harm caused to a child where abuse or neglect was known or suspected and the child has died or seriously harmed (Her Majesty's Government, 2010). The Local Safeguarding Children's Board must consider the circumstances and decide if an SCR should go ahead where there were concerns organisations did not work together to effectively safeguard the child.

SCRs have been widely undertaken, and until 2010 were not often published. In submitting evidence to the Munro review, organisations described the administrative and time burdens of carrying out an SCR, although learning is also evident. Despite this, locally commissioned SCRs are not considered by some researchers as an effective learning mechanism or tool (Sinclair and Bullock, 2002).

This could appear to be borne out by the findings from examinations of child deaths and cases of abuse, with consistently recurring themes such as poor

inter-agency communications and information sharing, lack of effective practice by professionals, inadequate training and/or supervision of front line staff (Dingwall, 1989). The key question is that if the system for supporting improvement in safeguarding practice was still seeing similar failures in protecting children recur, are managers and policy makers focussing on the wrong improvement methodology?

Lord Laming's seminal report following the death of Victoria Climbie cautioned against an over-reliance on performance indicators that were focussed on processes and timescales, as opposed to systems that measured quality and outcomes for children and young people (Laming, 2009). He particularly felt that they also created silos between organisations. Devaney (2008) concurs, and contends that performance measures create diversionary practice which leaves frontline practitioners confused about nationally set priorities that are not relevant to their immediate priorities with families.

For Fish however, the use of performance indicators should not be dismissed as they can be important tools to support the measurement of decision making in complex organisations (Fish, 2009).

Brandon et al (2009) however found that more regulation and guidance did not result in improved clarity in certain aspects, such as sharing of information and balancing the right to confidentiality with the imperative to protect children. Peel and Rowley (2010) concur that increasing complexity of legislative and regulatory requirements can create confusion amongst front line professionals and undermine confidence and competencies.

Glasby's work on partnership working in health and local government argues that by itself structural change rarely achieves its original objectives, but that the cultural dimension is a greater factor (Glasby, 2012).

2.4.2 Continuous Improvement Models

In the private sector the use of continuous improvement models is commonplace and has a long history extending back at least to Deming and his model of Plan, Do, Check and Act (Deming, 1950). The model establishes a continuous four-step cycle which, over time, eliminates waste and thus

improves quality. More recently, continuous improvement is described as *'getting better all the time'* (Fryer et al, 2007). Fryer also describes the tensions in public services which are subjected to the demands of government, especially new administrations. She goes on to contend that consequent reorganisations contribute to further organisational instability and uncertainty, the very aspects the improvement seeks to avoid.

Another key feature for public services is the three-dimensional nature of these organisations, consisting of policy, managers and professionals (Talbot, 2003). Each of these domains has its own methods of working and cultures, which in turn affects how policy is eventually translated into practice.

It is important as well that despite its undoubted success in many businesses, continuous improvement is not *always* successful, can be hard to sustain in the long term and requires a supportive culture within the organisation if it is to succeed (Besant et al, 1994). This latter perspective can be useful when one considers how government, as well as health and social care organisations, have approached improvement work through learning from cases of child abuse.

The aspirations of Government and others to learn from the death of Victoria Climbie, so that such a death did not occur again, was a natural and human response (House of Commons Health Committee, 2003).

As we have seen earlier, a common response of Government and agencies to highly publicised cases of child abuse has been to set up reviews or inquiries. These primarily look to reconsider the legislative framework to assess if that needs strengthening, and to consider if there is a need for new or different guidance to improve practice. They also of course give an opportunity to make public the deficiencies of local services and staff, as well as demonstrate a Government's determination to eliminate risks of harm to children (Lachman and Bernard, 2006).

Stanley and Manthorpe's (2004) research describes the benefits of insight as a result of inquiries and the scope they offer to generate improvements in the way health and social care function by developing evidence-based practice. They argue however that because of a *'blame driven environment'* they fail to

adequately deal with the real day-to-day pressures practitioners face when dealing with child protection.

The unprecedented (at the time) attention given to the review of Victoria Climbie's death prompted concern that as well attention would be diverted to exceptional cases of abuse, rather than the larger groups of vulnerable children (Garboden, 2010).

Some distinction needs to be made between nationally commissioned reviews and those commissioned locally – the latter will tend (but not always) to have a lower public profile. Thus deficiencies in systems and individual professional performance can be identified and addressed away from the glare of publicity.

Another form of learning and continuous improvement is through peer reviews, where an organisation carries out a review of another organisation providing the same range of services. Peer reviews are common in clinical practice, and are being adopted increasingly across health and social care as a means of offering a counter-balance to the otherwise more judgmental approach taken by the inspectorates (Nicolini et al, 2011).

Similarly, sector led improvement is also seen as a means to improve performance in public services, with organisations working collaboratively to share best practice.

Improvement may be seen as something other than, or as well as, a series of incremental improvements through continuous adjustments. Bhuiyan and Baghel (2005) stress the importance that radical change can be prompted by new ideas or technologies – we can see evidence of this in the way in which Government policy has driven change, such as formalising collaborative safeguarding working and commissioning of children services through Children's Trusts, following independent inquiries as a result of a high profile child death.

2.4.3 Systems Methodology Model

Some thirty years after the Labour Government's public health–led approach to tackling the perceived underlying causes of child abuse and neglect, the

Coalition Government announced a different approach whilst acknowledging the importance of a holistic view of the child.

The proposal (under consultation at the time of writing), through an independent review of safeguarding children, is that there needs to be greater emphasis on professional practice and the views and experiences of children and their families, and less about regulation and procedures (Munro, 2011). The reasons for this are numerous, but can generally be summarised by three features.

Firstly, a political cross-Government imperative to reduce what has been perceived as wasteful bureaucracy and red tape. In the safeguarding context this is epitomised by the Government's plan to cut safeguarding guidance down from approximately 700 pages to one tenth of that under the headlines *'Bureaucracy axed to put vulnerable children first'* (DfE, 2012).

Secondly, a stated desire to shift from seeing failure rooted in individual professional actions or events, to seeing safeguarding practice as something that takes place in a complex, ever-changing 'socio-technical system' (Fish et al, 2012).

Thirdly, to encourage a combination of local determinism in the way reduced guidance will be applied, with the explicit recognition that all involved in safeguarding need to be realistic of the extent to which professionals can keep children safe from all harm (DfE, 2012; Munro, 2012). The latter is not to accept tragic cases such as Baby Peter, but to understand that sometimes adults can successfully conceal the harm they cause to children (Chapman, 2004). Here the focus is on the outcomes from the perspective of the child and her/his family, and less on the ability of organisations being able to demonstrate fidelity to processes or outputs.

To encourage a culture where reviews and investigations are not blame-driven, the Munro review (Munro, 2011 and 2012) has renewed interest in using systems methodology as a means of learning from mistakes and good practice. The approach has its origins in systems thinking where organisations can be seen as systems (eg consisting of planning, delivery, management etc) and as part of a system in a wider context (Katz and Kahn, 1978).

This approach has well developed origins in as diverse sectors as aviation and the health service. The concept is one which sees actions as much governed by the context in which individuals work as it is about the actual actions they have taken. Similar analysis applies to studies in health services into the main reasons quality improvement initiatives fail – mainly because of external factors and organisational processes (Alexander and Hearld, 2011).

Undertaking reviews using this methodology therefore is not about assigning blame, but taking a holistic viewpoint from all the key actors involved so that a full picture and understanding of why something took place can be achieved (Woods and Cook, 2002).

In the health service the established use of systems methodologies on individual cases provides a '*window*' into the system itself, and gives insight into what works well and what doesn't (Vincent, 2004). Current proposals (at time of writing) include the publication of all Serious Case Reviews and other forms of learning so that the public can come to a view as to the effectiveness of local services (Munro, 2011).

Understanding the contextual background means that systemic contexts that encourage or permit errors can be addressed, creating a position where it is easier for the individual to do the right thing than it is to do the wrong thing (Institute of Medicine, 1999).

Compared therefore with the single loop theory described earlier in performance management, we have here a double-loop of learning and development (Argyrus and Schon, 1978). In this approach there is greater emphasis on continuous learning, where attention is given to the importance of organisational culture, policies and objectives which affect change – thus in this environment, managers are given greater powers to formulate best practice, learn continuously from practice and service delivery, and are empowered to make improvements and be responsible for change.

Reflective learning has been recognised as a feature of human psychological development, with Piaget's (1965) developmental theories informing more recent theories such as Argyrus', and in employees and organisations (Kolb, 1984). The importance of reflection is critical for employees to learn from errors

and experience and improve their performance, although McIntosh (2010) contends that this is not widespread in the NHS and takes many years before learning is widely spread.

2.5 Conceptual model

Drawing on the above models and theories, the conceptual framework set out in Figure 3, encapsulates the path of policy development and implementation, taking into account key influencing factors. It is designed within the generally accepted ecological model for child development and safety (Bronfenbrenner, 1979 and Gilbert, R. et al 2009).

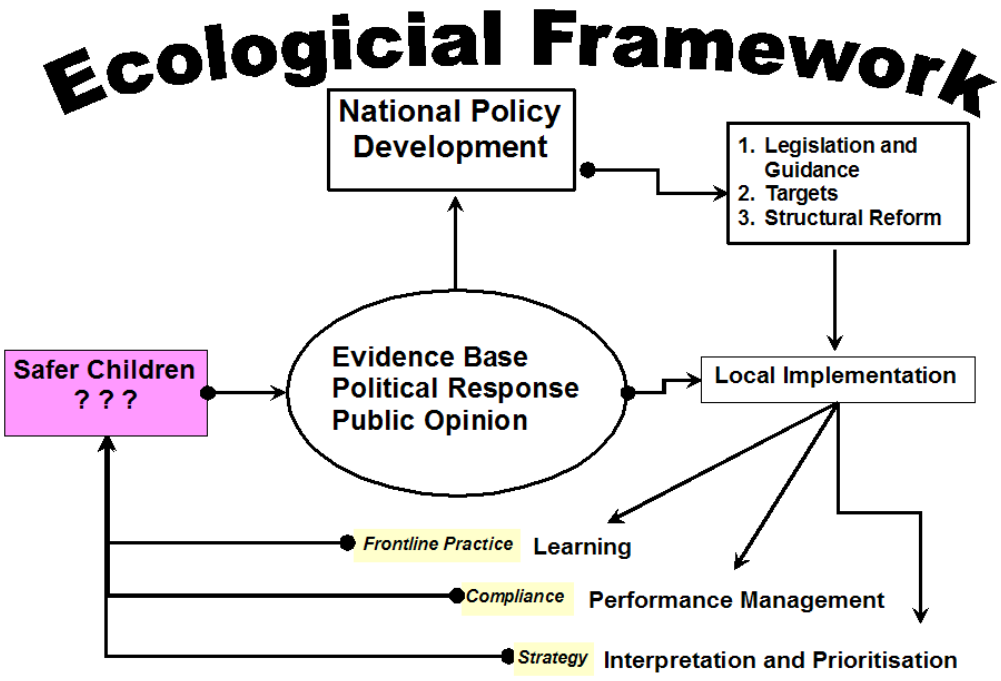

Figure 3 - Conceptual Framework based on Ecological Model

At first glance the framework does have a directional flow, from national policy development to local implementation, to safer children and then looped back to inform national policy development. However, the inter-relationships of the forces or activities within the framework have the capacity to affect others at any time, therefore the model is not purporting to be a fixed sequential one (Davies, 2004).

Three of the main drivers for national policy makers are identified as political responses and public opinion (often to individual perceived safeguarding failures), and the gathering and presenting of evidence from research and practice (Prime Minister's Strategy Unit, 2004).

The combination of these three influencers then can prompt legislators to use their powers to lay legislation, regulations and describe structural systems they expect in place locally to reduce safeguarding risks to children (Lachman and Bernard, 2006).

Requirements set by national government are interpreted and combined at a local level with other local priorities, by managers who in the recent past for safeguarding have been criticised for not doing enough to address systems failings (Lord Laming, 2009). Three priority features at local level are drawn from the literature review.

Firstly, there is Learning through formal case reviews, case management, research etc, which informs *Practice* through frontline services, which for Jack and Gill (1997) and Munro (2011) has not always been a cycle of continuous improvement but one laced with blame.

Secondly, local agencies establish Performance Management systems, through targets which are set locally and by Government, to measure service and performance and achieve Compliance with the desired level of service. The framework does not at a theoretical level link this to Learning because they may be incongruous with each other as targets have, previously, usually been set nationally (Devaney, 2008).

Thirdly, at the local level there is *Interpretation* of policies and guidance and *Prioritisation* of the use of resources, through partnerships such as statutory Local Safeguarding Children's Boards, to set safeguarding *Strategy*. These Boards also have a duty to promote their role with the public in local areas. Taken collectively these should lead to improved safeguarding outcomes for children (France et al, 2010 and Horwath and Morrison, 2011).

The continuous cycle continues as further evidence is gained from safeguarding cases which in turn prompts political responses and public opinion which may lead to further national policy developments.

The conceptual framework recognises that just as national governments react to evidence, public opinion and politicians' views, so too do local governments and local partnerships, including health services (Parton, 2011). This forms the basis for the research investigation in the following chapters.

2.6 Summary

The chapter gives a literature review of the key research undertaken for safeguarding children and the way in which Government policies are developed. A conceptual model provides a framework to explore the links between the development of policy and its implementation, within an ecological context for the development of the child and the protection of his/her welfare.

Pertinent issues on the influencing factors on safeguarding health managers are identified in relation to social context (publicity), government policies and translation to local implementation, and improvement methodologies, which inform the direction of enquiry in Chapters Three and Four.

CHAPTER 3. METHODOLOGY

3.1 Introduction

This chapter begins with the research philosophy used by the researcher, explaining why this stance was taken. The chapter then covers the research strategy which governed the work, and why other methods were not used. This is followed by a progressive description of the research design, the testing of the research instrument, and the consideration given to ethical issues in the wider context and with appropriate reference to the context of the NHS.

3.2 Research Philosophy

The author has taken the epistemology for both safeguarding policy development and implementation into practice as being an interpretivist one. That is, it is complex and influenced by a number of social, political and organisational factors, as well as individual behaviour. Easterby-Smith et al (2002) emphasise the importance of the researcher understanding his stance so that the most appropriate methodologies, and the research limitations, may be better identified from the outset of the research.

From both safeguarding management and practice perspectives, this interpretivist approach sees managers as acting on their interpretation of a given context, or reality. Social constructionism thus sees the inter-relationship and influences between context and the individual/s, and assumes individuals act differently because of their perception of reality (Gray, 2009).

The ontological approach is a subjectivist one, where the context in which managers are working is regarded as a dynamic and ever changing one. This refers to both internally in terms of their organisation, and externally in terms of outside forces as demonstrated in the preceding chapter.

Glasby (2012) stresses this difference from an objectivist approach which would see structural and organisational as being the dominant influences on manager behaviour, as opposed to the cultural dimension being a dynamic development arising from the behaviour of employees.

An interpretivist stance is recognised by the researcher as the dominant axiology, involved as he is intrinsically in the research topic and with the research actors (the managers) (Crotty, 1998; Williams and May, 1996). Fay's (1996) conclusion that agents (or actors) are such because of the situational power derived from their role within an organisation is pertinent to the manager subjects of this research, as is the interplay between them (Tietze et al,2003).

The chosen research instrument, a census of a relatively small number of strategic managers using a questionnaire, allows for an exploration of any differences, as well as similarities in managers' views and actions. In effect examining the *'multiple realities'* where *'there is not a single unitary reality that can be appealed to outside human perception'* (Dyson and Brown, 2006).

3.3 Research Strategy

This section sets out why the paradigm and methodology were selected, and the research methods which were rejected and why.

3.3.1 Justification for the selected paradigm and methodology

The research strategy is through a census, specifically the use of a questionnaire. This deductive approach is a useful exploratory device with the potential to cover a number of issues (Saunders et al, 2009). The census, or survey, is normally used with large numbers of potential respondents, and is increasingly used online to seek anonymised views on a wide range of topics (Witmer et al, 1999). The administrative benefits of providing the questionnaire online can be significant, and some systems (including the one used in this research) can provide anonymity (Hair et al, 2011)

The adopted strategy is especially pertinent to the research question which seeks to explore the different influences on safeguarding managers' behaviours – a questionnaire enables a range of data to be collected in a standard way, and, in this context, with each individual able to complete the form in private and anonymously.

Questionnaires take different forms but broadly are either administered by the individual respondent, or the researcher/interviewer. The following sections

describe in more detail the justification for opting for the former method, using an established online survey company.

The questionnaire was targeted at the strategic health safeguarding managers in PCTs. Because this number was relatively small the approach was as a census of the whole group, as opposed to a survey involving sampling.

An interpretivist paradigm is used because of the researcher's concern to understand the key factors influencing how managers are acting in the way they say they are, as opposed to an examination of organisational structures and systems.

The limitations of the research strategy used was that it would not give a deeper insight into the responses, including in particular some of the motivational aspects of managers' behaviours and actions. Ideally questionnaires are relatively short to encourage a good response from the target group, which may limit the range of the researcher's enquiry.

3.3.2 Rejected methods

The researcher discounted the use of mixed methods research, combining interviews and questionnaires because the respondents could be easily identified. This may have then influenced the responses given . The relationship of the researcher to the research subjects means that there would be a strong risk of those being interviewed face to face being reluctant to respond openly to someone who ultimately had a performance management role with them.

For example, one of the eight questions asks managers if the work of the health authority (the researcher's employer) had any effect on their work prioritisation and how they undertook their work. It could be argued that it would place manager/s in a challenging position to answer no to this question in front of the researcher, an issue not unique to this context (Sim, 1998).

The researcher's understanding of this relationship in conducting research into his or her's own organisation, or with colleagues, is *"a key part of appreciating the situatedness of all knowledge"* (Cassell and Symon, 2012).

Group interviews were considered as a means to gain a more qualitative aspect to the research than a straightforward survey could give, providing an opportunity to give perceptions and opinions (Krueger and Casey, 2009). There is a risk with this methodology that the researcher gains the views of the group's most articulate members, rather than the views of each individual within that group (Wilkinson and Birmingham, 2003), and group dynamics can shape and impact on responses

The anonymous nature of data collection meant that the researcher did not require submission of the proposal to an NHS research ethics committee (see section 3.6 below).Should that have been the case, it was likely that the process could have delayed the undertaking of the research instrument by as much as six months.

Because of the hierarchical relationship and the need for confidentiality, the researcher did not opt for either follow up interviews or free text facilities for responses because of the risk of being able to identify managers from their responses. This did prevent the opportunity to subsequently explore responses in more detail.

3.4 Research design

3.4.1 Design of Instrument

The researcher asked a small group of the targeted managers, following a regular regional safeguarding meeting, if they would be willing to complete a questionnaire as part of the MBA. (It should be noted that in the NHS requests such as this are not uncommon).They were reassured participation would be anonymous. The feedback was positive and the survey was then designed in draft form.

Three individuals involved in safeguarding, one of whom would be asked later to complete the instrument as part of the main group, were asked for their opinions on the draft. They had limited comments, the principal one being extending the response options to each question from three to four and giving definitions for each of the scales – thus managers were asked to what extent a

specific context influenced *What* they did, and *How* they did it, against the following four scales:

a. Significantly = Has caused a profound change, requiring significant adaptations to what you do or how you do it in relation to safeguarding

b. To a large extent = Has required adaptations to what you do or how you do it in relation to safeguarding

c. To some extent = You have had to make some relatively minor changes to what you do or how you do it in relation to safeguarding

d. Not at all = Nil changes

The test group contended that this would allow for a more sophisticated analysis, particularly by inserting the scale of *To a large extent*. In the absence of a qualitative methodology this would give an increased nuance to responses and provides an opportunity for managers to distinguish between some change and significant change.

It was also contended that all managers choosing to complete the questionnaire should be required to provide an answer, otherwise no responses would significantly affect analysis because the cohort was relatively small.

Other comments were largely restricted to use of language, which were incorporated in the final setting of the questions.

The researcher then worked with NHS North West's Communications Officer to set out the actual design layout so that the questions appeared in a logical and consistent way online. Dillman (2007), and Balnaves et al (2001) stress the importance of layout to questionnaires, ensuring there is a logical flow to the questions and that categories, or scales, are kept constant. Similarly, grouping related questions together is important for the respondent to follow the flow of the questions (McNabb, 2008)

Three staff, unconnected with the research or the subject matter, were asked to test the questionnaire online. Their views on its structure and the ease of completion informed the final online version. A test of their completed

questionnaires included the researcher being able to check that the meaningful aggregation of returns into tables was possible and straightforward. The test also included verification of the hyperlink that would direct managers to the online questionnaire.

3.5 Research procedures

The census (Appendix A) was to be sent to the twenty-six strategic safeguarding children lead managers in the PCTs across the North West of England. These consisted of five PCT Executive Nurses, and twenty-one Designated Nurses. Together they are the most senior strategic and operational commissioning safeguarding children's leads in the region's PCTs. The research restricted the target group of managers to those who had the most direct relationship with the health authority, whilst responsible for policy implementation at the local PCT level.

It was clear during early verbal communications with the group ahead of the census commencing, that two managers would be on leave and thus unable to take part, leaving twenty-four managers in the census.

A request to complete the census was sent by email on Friday, 22nd June (Appendix B). Email communication is now the most common form of written communication from NHS NW to PCTs, and would be the most efficient way to include a link to the SurveyMonkey website where the census was hosted (SurveyMonkey, 2012). Managers were reminded about the returns being anonymous and the author cited a reference to the NHS Ethics process to reassure them on this point.

An email reminder was sent on the morning of Monday, 2nd July, reminding managers that the census would end by close of business on Tuesday, 3rd July, and repeating the information sent in the first email. The anonymised returns were collated once the census period ended.

3.5.1 Analysis of data

The online facility available from SurveyMonkey meant that the anonymised completed questionnaires were automatically loaded into a spreadsheet. From

this, aggregates for each question were compiled into tables, which are set out in the following chapter and analysed in detail.

In brief, fourteen managers completed the survey. This represents 58% (14 out of 24) of the group available to complete the census, which according to Babbie (1986) would be considered a more than adequate response as it is above a 50% response rate.

3.6 Ethical considerations

A key consideration when adopting the research methodology was the relationship of the researcher with the managers identified to form the census. Whilst not line managing the managers, the researcher does have a relationship that is hierarchical in that they report to him on safeguarding performance. For a number of the managers at the time of the census this involved some performance management accountability.

Consequently, managers asked to participate in the questionnaire were reassured that their participation would be entirely confidential – the researcher could not identify who took part, and who gave which answers. The reassurance was given in each communication inviting participation. The researcher confirmed that the questionnaire and the methodology had been approved by NHS North West in terms of ethical approval.

The application to NHS NW for ethical approval was given on the 2nd March 2012. It was given on the basis that the research does not involve NHS patients in any way. The response from the ethics team confirmed that in addition the research did not require NHS research governance approval either because the survey data was to be collected anonymously.

3.7 Summary

This chapter has set out the philosophical approach used. The adopted research strategy is presented with reference to the topic area as well as academic theory, whilst rejected research methods are explained. The process for the design of the research instrument is given, and an outline for the structure of the questionnaire. Ethical issues are discussed and NHS standards for the conduct and use of the research are set out. The basis is therefore in

place for proceeding to a description of the findings from the questionnaire in Chapter Four.

CHAPTER 4. PRESENTATION OF FINDINGS

4.1 Introduction

This chapter gives details of the findings from the research undertaken using the instrument described in the preceding chapter. The following chapter analyses the findings in the context of the literature search.

4.2 Findings of the research

The researcher received online individual, anonymised responses, which have been collated into tables for each question. A summary of the findings in table form for each of the questions is given in Appendix C. The findings are presented in the order in which the questions were presented online. Each question asked the manager to respond to their assessment of the on them impact on *What* managers did e.g. priorities, and then their assessment of impact on *How* they carried out their role.

Managers were not given the option of not providing an answer, because the online questionnaire required an answer before proceeding to the next question. An explanation why the researcher used this technique is described in the previous chapter. If managers were unhappy with this they could simply opt out of completing the questionnaire and their entry not be retained online. Managers could not see the responses given by their colleagues.

4.2.1 Question One – Munro Review

The Government, at the time of writing, was consulting over proposals recommended in the Munro review. The proposals were set out in Chapter Two. Although the review would have a limited impact on respondents because of this timing, the question sought to identify to what extent emerging policy and practice changes were beginning to affect strategic managers, months before guidance is issued.

The question asked:

1.To what extent has the Munro review changed, or begun to change, What you do and How you do it?

Table 1 gives a summary of the answers.

Q1. To what extent has the Munro review changed, or begun to change:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	7.1% (1)	0.0% (0)	78.6% (11)	14.3% (2)	14
How you do it?	7.1% (1)	14.3% (2)	71.4% (10)	7.1% (1)	14

Table 1 - Answers to Question One, Munro Review

Two of the fourteen managers reported no changes as a result of the Munro review for *What* they did, and one said no change for *How* they did it. Three-quarters of managers (12 managers) said that there was some change to *What* they did, and slightly less (by one person, 10 compared with 11) said it affected *How* they worked.

Only one manager answered that the Munro review was having a *Significant* impact on priority setting and *How* they worked.

4.2.2 Question Two – The impact of publicity

Question Two gave managers an opportunity to grade the extent, if any, to which national publicity affected their safeguarding work. This question would test some of the assumptions identified in the literature search about external, non professional influences and the impact of part of the ecological environment.

The question asked managers:

2. To what extent has general (national) publicity on safeguarding changed what you do and how you do it?

The responses are given in Table 2 below.

Q2. To what extent has general (national) publicity on safeguarding changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	7.1% (1)	57.1% (8)	28.6% (4)	7.1% (1)	14
How you do it?	0.0% (0)	71.4% (10)	21.4% (3)	7.1% (1)	14

Table 2 - Answers to Question Two, Publicity

More than half the number of managers reported that the impact of publicity as being *to a large extent* (eight managers), with another one saying it was *Significantly* and another four *To some extent*. Ninety-three per cent of managers therefore reported publicity having an effect on what safeguarding work they did.

The same per cent report publicity having an effect on how they carried out their work, with ten describing this as *to a large extent*.

4.2.3 Questions Three and Four – The role of performance and continuous improvement methodologies

Questions Three and Four addressed two key aspects of the performance and continuous improvement methodologies used in the field of safeguarding: individual case reviews and generic or service reviews.

The questions were:

3. To what extent have individual safeguarding cases (e.g. Serious Case Reviews, Independent Medical Reviews *etc) changed What you do, and How you do it?*

4. To what extent has a Joint Review changed What you do, and How you do it?

As described in Chapter Two, a Joint Review is an inspection carried out jointly by Ofsted (the Office for Standards in Education, Children's Services and Skills) and the Care Quality Commission (CQC) into safeguarding and, in the period leading up to the research, care provided to Looked After Children (LAC).

Generally, Ofsted deals with education and social care matters, whilst the CQC deals with health services.

The responses to the two questions are given below in Table 3 and Table 4.

Q3. To what extent have individual safeguarding cases (e.g. Serious Care Reviews, IMRs etc), changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	21.4% (3)	50.0% (7)	28.6% (4)	0.0% (0)	14
How you do it?	21.4% (3)	50.0% (7)	28.6% (4)	0.0% (0)	14

Table 3 - Answers to Question Three, SCR and IMR learning

Q4. To what extent has a Joint Review changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	14.3% (2)	50.0% (7)	35.7% (5)	0.0% (0)	14
How you do it?	14.3% (2)	50.0% (7)	35.7% (5)	0.0% (0)	14

Table 4 - Answers to Question Four, Joint Review

These were the only two questions of the eight in which all managers reported that their priorities, and the way they work, had changed as a result of these two improvement methodologies. The answers to both questions, and to the effects on *What* they did and *How* they did it, were very similar, with the only difference being one more manager reporting that individual safeguarding cases had a more significant effect than a Joint Review.

4.2.4 Question Five– Government influence via Performance Management (SHA)

The role of the regional Government agency in influencing change through policy implementation at supra local levels was explored in Question Five. This asked:

5. To what extent has general advice/information from the SHA changed What you do, and How you do it?

In relation to Question Five, the question was restricted to *general advice/information* as opposed to occasions where the SHA communicated with a PCT through formal and direct routes over a specific issue. The primary reason for this is explored further in Chapter 5, but would mainly involve advice on generic performance requirements, standards and compliance.

Table 5 gives a summary of the answers.

Q5. To what extent has general advice/information from the SHA changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	35.7% (5)	14.3% (2)	42.9% (6)	7.1% (1)	14
How you do it?	21.4% (3)	35.7% (5)	35.7% (5)	7.1% (1)	14

Table 5 - Answers to Question Five, SHA

Thirteen of the fourteen respondents (93%) said that their priority setting and the way they carried out their work was affected by the SHA. Five managers (36%) reported that the SHA had an influence that was Significant in their priority setting, although this dropped when they were asked to what extent in *How* they did their work (3). Overall more influence for priority setting was described as *To some extent* (6 managers) and one less for how they worked.

One manager reported that there was no effect on their work from the SHA advice/information, and another manager reported that there was no effect on their work from the general advice/information.

4.2.5 Question Six– Government influence at a national level

The Department of Health, acting on behalf of Ministers and parliament, sets broad and specific policies and targets for local services. In the area of child safeguarding the Department for Education plays the lead statutory role but NHS organisations have local statutory duties.

Question Six is similar to the previous question, but focuses on the influence of central government departments. The question asked:

6. To what extent has general advice/information from the Department of Health and/or Department for Education changed What you do, and How you do it?

Table 6 gives a summary of the answers.

Q6. To what extent has general advice/information from the Department of Health and/or the Department for Education changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	35.7% (5)	14.3% (2)	42.9% (6)	7.1% (1)	14
How you do it?	14.3% (2)	21.4% (3)	57.1% (8)	7.1% (1)	14

Table 6 - Answers to Question Six, Department of Health

The responses given show that more than half the managers (57%, 8), say that the impact is *To some extent* on *How* they work, and 42 per cent (6) on priority setting. An important minority of 35 per cent (5) describe the latter influence as *Significantly* but this drops to 14 per cent (2) for *How* did their work.

One manager (7%) said that there had been no influence for either aspect.

4.2.6 Questions Seven and Eight - Structural Influences

Questions Seven and Eight covered the influencing impact of PCTs (the managers' employer) and partnerships on the work of the strategic safeguarding managers.

Question Seven sought to identify to what extent organisations influenced the work of the safeguarding managers. In one sense the answers to this would seem to be an obvious one, in that they would influence, but the answers will be compared with answers to other questions in the following chapter to identify any significant differences. The answers would also help inform the analysis from the literature search specifically on health organisations' impact on safeguarding issues.

The question asked:

7. To what extent has your organisation changed your safeguarding work in terms of What you do, and How you do it?

Table 7 gives a summary of the responses.

Q7. To what extent has your organisation changed your safeguarding work in terms of:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	57.1% (8)	21.4% (3)	14.3% (2)	7.1% (1)	14
How you do it?	50.0% (7)	14.3% (2)	21.4% (3)	14.3% (2)	14

Table 7 - Answers to Question Seven, Own Organisation

One manager responded that their organisation had not influenced them in their priorities, and another in how they carried out their work. These were the exceptions, with the other twelve managers describing that they had been influenced. More than half (8) rated the influence as Significant in setting priorities, and half of all respondents (7) said this was Significant in how they worked.

Of the eight questions this was the one which elicited the strongest response in relation to Significant influences, with eight and seven managers respectively.

Question Eight sought to identify the influence of partnership working through the work of the Local Safeguarding Children's Board (LSCB). As previously described, the context in which organisations function is critical generally, and for safeguarding in particular because of the statutory status of LSCBs with NHS organisations as statutory partners.

The question asked:

8. To what extent has the Local Safeguarding Children's Board changed your safeguarding work in terms of What you do, and How you do it?

Table 8 gives a summary of the responses.

Q8. To what extent has the Local Safeguarding Children's Board changed your safeguarding work in terms of:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	21.4% (3)	28.6% (4)	42.9% (6)	7.1% (1)	14
How you do it?	14.3% (2)	28.4% (4)	50.0% (7)	7.1% (1)	14

Table 8 - Answers to Question 8, LSCBs

Although thirteen out of fourteen managers responded that LSCBs had some effect on prioritisation and how they did their work, the most common single scale for both questions was *To Some Extent* (6 and 7 respectively). Half of managers (7) reported the influence on prioritisation as *Significantly* and *To A Large Extent*. Two respondents reported that LSCBs had no effect on their work.

4.3 Overview of responses

Table 9 gives a total summary of the responses from the above eight questions for the impact on *What* managers do.

Summary of Responses to What You Do:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do? (N)	28	33	44	7	112
What you do? (%)	25%	29%	39%	6%	100%

Table 9 - Summary of Responses to What You Do

The overwhelming number of responses (105, 94%) indicated that in relation to the questions there had been some impact on *What* managers did. Seven (6%), said that there had been no influence, with only the two questions relating to improvement methodologies registered no scores in the *Not At All* scale,

indicating all fourteen managers had been influenced. One quarter (28, 25%) of responses said the impact had been *Significant*.

Table 10 gives a total summary of the responses from the above eight questions for the impact on *How* managers undertake their role.

Summary of Responses to How You Do It:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
How you do it? (N)	20	40	45	7	112
How you do it? (%)	18%	36%	40%	6%	100%

Table 10 - Summary of Responses to How You Do It

Once again, the majority of responses (105, 94%) indicated some level of influence. Seven (6%) responses said there had been no influence. Again, only the two questions relating to improvement methodologies registered no scores in the *Not At All* scale, indicating all fourteen managers had been influenced. Less than one in five managers (18%) reported that there had been significant changes.

On aggregate across both parts of the questions, there are broad similarities between the responses on the influence on *What* managers do and *How* they do it in the total response rate. The assumptions and implications for this are explored in the following chapter.

4.4 Summary

Overall there was a sufficiently distinct differentiation in responses given across the majority of the eight questions to provide scope for analysis and comparison. The responses to *Not At All* were generally one or two managers, with the exception of Questions Three and Four where there no responses to this scale. The interpretation of the findings, and the context against the issues raised in Chapter Two, are examined in the following chapter.

CHAPTER 5. ANALYSIS AND CONCLUSIONS

5.1 Introduction

This chapter gives a detailed analysis of the findings set out in Chapter Four before reaching conclusions. A critical evaluation of the research methodology is given first. This is followed by conclusions about the research aims, and then conclusions in relation to the research question in the context of existing research. The author considers the limitations of the research which emerged during the research process before concluding with a presentation of opportunities for further research.

5.2 Critical Evaluation of Adopted Methodology

The research tool was intentionally set to a relatively small number of questions to encourage a satisfactory response rate (Dillman, 2007). This was achieved as 58% (14/24) of those available to complete the questionnaire did so.

The purpose of the research was to gain a general view into the factors which influence strategic safeguarding children's health managers in their prioritisation and work methodologies. If the researcher's brief had been to gain a more detailed insight, it would have been necessary to take a mixed methodology that includes a qualitative method, such as interviews, with the chosen quantitative approach, through a questionnaire. Interviews could have been one-to-one, or as a group/s.

Krueger and Casey (2009) describe the latter method as a *"carefully planned series of discussions to obtain perceptions on a defined area of interest in a permissive, non-threatening environment"*. This may have made greater use of the researcher's subjectivist ontology, where the dynamic managerial roles could have been explored in more detail.

However, because of the positional authority relationship between the author and the managers, opportunities to conduct interviews or cases studies were discounted because of the likelihood that the author's presence would affect responses (Holbrook et al, 2003). Consideration was given to utilising an independent researcher, but again the prospects of respondents being identified was high because of the relatively small numbers involved. This technique

would also have required NHS ethics approval and would have significantly delayed the research.

Whilst acknowledged in the research design stage, the limitations created by the absence of a qualitative method are evident in the analytical section below. Principal amongst these was the restriction on not being able to delve into greater depth into why respondents answered as they did, to identify specific motivational and influencing factors beyond the broad responses that questionnaires can generate.

Question Three, addressing some performance management methodologies, would have benefitted from having another sub question to distinguish between the range of performance management tools – thus to include one on targets (national and local).

It may also have been useful to be able to better distinguish between individuals as to the motivational factors behind their responses – although this is not always guaranteed in group interviews where concerns about giving what may be seen as unfavourable responses may distort answers to questions (Sim, 1998). Particular focus would have been beneficial in Question Seven, which asked:

Q7. To what extent has your organisation changed your safeguarding work in terms of What you do, and How you do it?

The responses to this question generated the most number of managers describing their work prioritisation and methods changing *Significantly*. Of research interest would have been to identify which aspects of their roles were changed, whether these were imposed on them or not, the impact of locally set targets and their opinion as to the merits of the changes.

Similarly, the responses to Question Eight on the impact of the Local Safeguarding Children's Boards could have been followed up with structured questions on the range and type of changes prompted by the Boards on the health managers.

5.3 Conclusions About the Research Objectives (Aims)

The research aims were focussed on the three methodologies commonly used in this context to improve safeguarding services in health:

- through performance management methodologies;
- continuous improvement methods used by Health organisations to learn from practice/serious incidents of Safeguarding (Serous Case Reviews, peer reviews, role of inspections)
- and a systems methodology approach.

This section explores the findings from the research undertaken, both through the literature review and the questionnaire, with the emphasis on the strategic management role.

5.3.1 Performance Management Methodologies

In 2.4.1 the general and specific research for health performance management was set out, with a description of the methodology as a 'single loop'. This interpretation sees targets either achieved or not achieved and remedial action not necessary or imposed as appropriate (Argyris and Schon, 1978).

There were three questions covering performance management. Question Three asks about Serious Case Reviews which focus on individual cases. Question Five refers to the impact from the Strategic Health Authority, which has a performance management role with the managers. And Question Seven asks about the impact from their organisation.

Question Three, on SCRs, was one of only two questions where all fourteen managers responded that there had been, at a minimum, some impact on their prioritisation and how they did their work. Whilst the level of impact was not graded by as many managers at the higher scale as for some other questions, the fact that all managers felt that this methodology was affecting their work is an important identification of the impact some performance management systems can have (Fish, 2009). Managers did not rank differently *What* they prioritised to *How* they did their work for this question, suggesting an even

impact to SCRs, which are prompted following serious harm being caused to a child where organisations are deemed to have failed to have acted effectively.

The impact of the SHA as an 'enforcer' of national targets, in Question Five, showed more managers indicating a *Significant* impact on their priorities and work than Question Three, but overall the influence is not as profound, with one manager reporting no impact at all. Caution may need to be applied to this question because respondents may have been overly sensitive to completing a questionnaire issued by the author as an SHA manager (Sim, 1998).

The strongest response from managers came in Question Seven, about their organisation's influence, which saw the highest number of managers scoring this impact as *Significant* for prioritisation (8) and how they did their work (7). The implementation of national targets can therefore be seen to be an important feature of influence (Devaney, 2008).

Overall the pattern of responses indicates that the closer the performance management function is to the individual manager, the greater the influence on their work (Das and Teng, 1998).

As a method of driving improvement through changing employee behaviour we can therefore see a very clear impact on this group of strategic health managers of the role of performance management.

5.3.2 Continuous Improvement Methodologies

Questions Four and Six referred to continuous improvement methodologies, the former covering Joint Reviews and the latter the role of Government Departments on general advice. This brings together the main influencers on public organisations (Talbot, 2003).

Joint Reviews are generally undertaken on a three year cycle and their recommendations tend to be generalistic, although it is evident that the majority of managers described their importance *To a Large Extent* and *Significantly* as a means of making continuous improvements. This was the only other question (besides Question 3) where all managers said there was an impact, illustrating the importance of the proximity of the improvement methodology to the managers.

The response from managers to this improvement method challenges the more negative perspective from Stanley and Manthorpe (2004) that they tend to be *"blame driven environments"*, although of course this research question tests the level of influence on managers, not its effectiveness.

The spread of responses for the influence from central government suggests a more mixed attitude to managers, although the influence here is still very evident.

Overall, there does seem to be a replication of the conclusion from the previous sub section, that local influences can be the more influential on these strategic managers.

5.3.3 Systems Methodology Approach

Questions One, Two and Eight addressed this approach, each taking a different aspect of the system in which safeguarding takes place. The first of these looked at how forthcoming reforms to safeguarding were affecting the managers, the second one the impact of public interest where expectations are high (Power, 2007), and the third the statutory LSCBs which encapsulates the ecological systems approach (Fish et al, 2012).

As with the previous sub sections, managers reported greater impact for the part of the system to which they are closest, the LSCBs, compared with the forthcoming nationally led reforms. A relatively modest impact was recorded by the managers for the Munro review, whereby more than 79 per cent (11) rated this as *To some extent* for prioritisation, and 71 per cent (10) for *How* they worked. This is most likely a reflection of the still evolving nature of that independent review, as described in Chapters Two and Four, so it may be difficult to make direct comparisons.

It is significant however that the majority of managers recorded that publicity, even at a national level, affected them *To a Large Extent*. This endorses the views of some researchers of the strong environmental impact public opinion has not only on politicians, but also managers (Lachman and Bernard, 2006).

The significant influence of public opinion on the managers is very apparent, reiterating Parton's (2011) view that it is not only national government that is

sensitive to negative publicity, but local agencies as well. This is demonstrated as well in the conceptual framework, 2.4 above, where one can see the flow of influence towards national government and local agencies.

5.4 Overall Conclusions About the Research Question

The research question was to examine how national policy to safeguard children is determined, and then how this is translated into practice by the health managers at a strategic level in the twenty-four PCTs in the North West.

The principal approach was not by assessing performance from nationally available data, but to focus on the key aspects of the ecological framework which influence strategic health managers, and the degree to which that takes place.

Eight questions were designed to test the managers' thinking on a range of factors which the literature review had identified as being of significance, and which the author had an interest in because of the forthcoming national changes to safeguarding policy and practice.

The conceptual framework contended that in the development of priorities and practice for child safeguarding, national and local agencies are affected by three key features:

a) *Evidence*, drawn from practice, reviews and research;

b) *Public Opinion*, usually arising from fatal failures in safeguarding systems and practice;

c) and the concomitant *Political* reaction to both these factors leading to legislative and cultural changes. A continuous, but not necessarily linear, cycle of change, aimed at improvement, was thus set in train.

This research has reiterated the importance of this triumvirate of factors, with the learning from reviews (both as part of performance management and continuous improvement) a major factor which affects the majority of these strategic managers either *Significantly* or *To a Large Extent*.

Researchers such as Jack and Gill (1997) and the Government's independent advisor (Munro, 2011), contend that reviews as improvement methodologies do not always yield sufficient improvements compared to the resources invested in them. However, these managers clearly reacted to reviews – both to change their priorities and to change their practice. The research aim did not include measuring the effectiveness of these changes, but nonetheless the fact that experienced managers all responded by saying they acted on reviews is important in identifying areas of influence on strategic managers in the health service.

The second key influencing factor, *Publicity*, was reported by the managers surveyed as a significant agency for change. Managers reported that the impact of publicity was more significant than the work of Government departments (led by Ministerial and political decision makers) and the SHA, both of which hold PCTs to account for performance, and in particular local individual and system failures.

This corroborates evidence from other research (Davies, 2004), and opens up the issue of whether Local Safeguarding Children's Boards should be doing more as part of their role in working with the public to publicise the work they do. Another dimension of this is pertinent to the Government's commitment to increase the transparency of safeguarding practice at a local level to the public, for example including the publication of SCRs (Munro, 2011). This move may be seen as adding further pressure to managers and their responses an early indication of this, although whether this pressure results in positive change was not tested in this research.

The other key outcome from the research was the influence of the managers' organisations on their work and priorities. In one sense this may appear to be obvious, as they are employees and would be expected to follow orders and organisational imperatives. Equally however, other investigations have highlighted the relative low priority health services can give to safeguarding at a strategic level (Laming, 2009). Furthermore, these are senior managers and could be seen as operating with a significant degree of self-direction. The current major reforms to the NHS, and the uncertainties over future roles and functions, may be an influence behind some of the managers' responses

(RCPCH, 2012; NHS Confederation, 2011) but further investigation is necessary to properly test this hypotheses.

One aspect that is potentially challenging to the ecological framework model was that the impact of working with LSCBs, which contain all the key strategic partners in a locality, was quite modest compared with the other influencing factors described above. The concern that LSCBs have been seen largely as local authority led vehicles may be a factor behind the health managers responses (Miller and McNicholl, 2003), but again this would need to be tested further.

The final key conclusion to be reached from this study was that the proximity of ownership of the improvement methodology has an effect on the managers. In essence, it would seem that the closer the methodology is to the managers operating environment, then the stronger the influence. A clear example of this is that although targets for safeguarding (for example ensuring all key staff have had Criminal Review Bureau checks, key staff have training, assessments are provided within certain timeframes etc) are usually set by Government and interpreted and applied locally, the health managers did not grade the influence from these bodies as being relatively significant. Instead they prioritised as more influential locally owned and applied methodologies such as reviews.

In conclusion, this last point is critical in the context of Government changes to increase the ownership, and thus setting, of local targets for safeguarding children to local agencies (Munro, 2011 and 2012). Together with similar moves for PCTs (and then their successor bodies, the Clinical Commissioning Groups), the shift in emphasis could yield improvements if PCTs and Local Authorities have a genuine sense of setting locally appropriate safeguarding priorities, with managers such as these seizing the initiative.

5.5 Limitations

The limitations of using a single method were described in 5.2 above and in the Chapter on Methodology. This was necessary in the context of undertaking the research in the author's field of work and responsibility, but a mixed methodology including follow-up interviews may have given greater depth to the research findings, although as previously cited this is not always guaranteed.

Concerns over the ability of respondents to give unequivocal answers, rather than what they did, is an issue. The triangulation of answers suggest this was not as obvious to the author as originally thought – nonetheless it may have had some effect and thus potential limitations need to be recognised.

5.6 Opportunities for Further Research

The research has identified three opportunities for potential future research.

The first is further study into the role of how health organisations direct and influence the priorities, and ways of working, of their strategic child safeguarding leads. Nuances of this research could usefully include identifying how the influence is exerted (for example, is this overt?), what has prompted this, and from the managers' perspectives, how this is received, interpreted and delivered. A study such as this would help investigate in more detail the agency which these managers recorded as having the most significant impact on them.

A second research opportunity would be to explore the difference identified in this research between managers' behaviours in priority setting as a result of reviews, and the current research which claims that reviews are often ineffective in changing practice. The principal research question would explore the reasons why managers continue to act in this way when the evidence suggests this is not an efficient and effective improvement tool?

The third area of research concerns testing the dynamics of public opinion in influencing strategic health managers, which they described as a significant factor. Research aims could include investigating how this opinion is communicated and interpreted by the managers, how they react to public opinion and to what extent their reaction is supported, challenged or not engaged with the other agencies in the safeguarding ecological framework.

CHAPTER 6. RECOMMENDATIONS

6.1 Introduction

This chapter introduces the author's recommendations following consideration of this original and existing research.

At the design stage for the research, the timetable for transfer of responsibilities from the SHA to successor bodies was March 2013, allowing time for the recommendations to be considered following publication of the research.

On the 13th of August 2012 this assumption changed when the Chief Executive of the national successor body advised the SHA and PCTs that they will be moving into new arrangements on a transitional basis from October 2012, and then permanently from April 2013 (Nicholson, 2012).

Because of the changes described in 1.4, the structural and accountability changes which the NHS is undergoing at the time of writing has meant that the researcher has used the learning gleaned from the undertaking of the research throughout the period of study.

The very recent change (in August 2012) in bringing the transfer timescale forward to October 2012 means that realistically the use of recommendations is limited because of the organisational and personnel changes that are taking place.

As a minimum however, the research proposes two recommendations which are achievable.

6.2 Recommendation One

Recommendation One is to share this research with the relevant senior management in the health authority and others, with a view to consider the findings and increase awareness of current thinking amongst the local strategic leadership for child safeguarding in NHS organisations.

6.3 Recommendation Two

Recommendation Two is to consider how the current SHA will prepare handover to its successor body/bodies in relation to supporting the PCTs' (and

shortly Clinical Commissioning Groups) strategic child health safeguarding leads, bearing in mind the perceived influences of the SHA and other agencies by the current PCT leadership group.

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Appendix A – Questionnaire

MBA Census questionnaire - Eustace de Sousa

Introduction

Guidance for completion

1. Please read all the questions before answering them.

2. The questions are sequenced so that you are giving your views on national, regional and local issues.

3. The questions seek your views on the extent what you do on safeguarding has changed and then to what extent how you do this work has changed.

4. In terms of the grades, the following may assist you:

a. Significantly = Has caused a profound change, requiring significant adaptations to what you do or how you do it in relation to safeguarding

b. To a large extent = Has required adaptations to what you do or how you do it in relation to safeguarding

c. To some extent = You have had to make some relatively minor changes to what you do or how you do it in relation to safeguarding

d. Not at all = Nil changes

5. Your answers will not be identifiable to you.

***1. To what extent has the Munro review changed, or begun to change:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

***2. To what extent has general (national) publicity on safeguarding changed:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

***3. To what extent have individual safeguarding cases (e.g. Serious Case Reviews, IMRs etc), changed:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

MBA Census questionnaire - Eustace de Sousa

***4. To what extent has a Joint Review changed:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

***5. To what extent has general advice/information from the SHA changed:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

***6. To what extent has general advice/information from the Department of Health and/or the Department for Education changed:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

***7. To what extent has your organisation changed your safeguarding work in terms of:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

***8. To what extent has the Local Safeguarding Children's Board changed your safeguarding work in terms of:**

	Significantly	To a large extent	To some extent	Not at all
What you do?	◯	◯	◯	◯
How you do it?	◯	◯	◯	◯

Appendix B – Email re census

From: Eustace De Sousa (NHSNW)
Sent: Friday, June 22, 2012 12:46 PM
To: NAMES OBSCURED

Subject: MBA Survey of Designated Nurses and PCT Cluster Executive Leads for Safeguarding Children

Dear Colleagues,

Some of you may be aware that I am undertaking an MBA at the University of Chester. I have completed the taught components and am now doing my dissertation, which is on safeguarding children in the health service.

As part of my dissertation I have to carry out an original research element, which is where I hope you can help.

I have designed a questionnaire that looks at some of the factors which may prompt local health safeguarding leaders to change priorities and practice.

I am only asking Designated Nurses and the PCT Cluster Executive Leads for Safeguarding for responses, so that I can manage the review of responses within a particular group of health professionals.

There are eight questions, each of which has two parts, and you are asked to rank the extent to which these factors *may* have influenced what you do, and how you do it, with regards to safeguarding.

The questionnaire should take less than 15 minutes to complete.

I hope that you can assist me with this – to complete the questionnaire please use the link below. If you cover more than one PCT /LA area, can I ask you to complete the questionnaire for each area.

https://www.surveymonkey.com/s/DLJBHX7

All responses will be confidential - you are not asked to leave your name and the questions are set so that you cannot be identified, in line with the approval I have had through the ethics committee.

Many thanks for your support – I will leave the survey open until close of play on 3rd July.

If you have any queries please do contact me.

Best wishes

Eustace

Eustace de Sousa
Associate Director
Children and Maternal Health
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Manchester
M1 3BN

Appendix C – Table of questionnaire responses

MBA Census questionnaire – Eustace de Sousa

1. To what extent has the Munro review changed, or begun to change:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	7.1% (1)	0.0% (0)	**78.6% (11)**	14.3% (2)	14
How you do it?	7.1% (1)	14.3% (2)	**71.4% (10)**	7.1% (1)	14

2. To what extent has general (national) publicity on safeguarding changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	7.1% (1)	**57.1% (8)**	28.6% (4)	7.1% (1)	14
How you do it?	0.0% (0)	**71.4% (10)**	21.4% (3)	7.1% (1)	14

3. To what extent have individual safeguarding cases (e.g. Serious Care Reviews, IMRs etc), changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	21.4% (3)	**50.0% (7)**	28.6% (4)	0.0% (0)	14
How you do it?	21.4% (3)	**50.0% (7)**	28.6% (4)	0.0% (0)	14

4. To what extent has a Joint Review changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	14.3% (2)	**50.0% (7)**	35.7% (5)	0.0% (0)	14
How you do it?	14.3% (2)	**50.0% (7)**	35.7% (5)	0.0% (0)	14

5. To what extent has general advice/information from the SHA changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	35.7% (5)	14.3% (2)	**42.9% (6)**	7.1% (1)	14
How you do it?	21.4% (3)	**35.7% (5)**	**35.7% (5)**	7.1% (1)	14

6. To what extent has general advice/information from the Department of Health and/or the Department for Education changed:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	35.7% (5)	14.3% (2)	**42.9% (6)**	7.1% (1)	14
How you do it?	14.3% (2)	21.4% (3)	**57.1% (8)**	7.1% (1)	14

7. To what extent has your organisation changed your safeguarding work in terms of:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	**57.1% (8)**	21.4% (3)	14.3% (2)	7.1% (1)	14
How you do it?	**50.0% (7)**	14.3% (2)	21.4% (3)	14.3% (2)	14

8. To what extent has the Local Safeguarding Children's Board changed your safeguarding work in terms of:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	21.4% (3)	28.6% (4)	**42.9% (6)**	7.1% (1)	14
How you do it?	14.3% (2)	28.4% (4)	**50.0% (7)**	7.1% (1)	14

Summary of Responses to What You Do:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	28	33	44	7	112
How you do it?	25%	29%	39%	6%	100%

Summary of Responses to How You Do It:					
	Significantly	**To a large extent**	**To some extent**	**Not at all**	**Response Count**
What you do?	20	40	45	7	112
How you do it?	18%	36%	40%	6%	100%